APPENDIX B

# Quality of Services Focus Review Provider Report

Missouri Department of Mental Health-Division of Developmental Disabilities

**Provider Name**: **Date(s) of Quality of Services Focus Review:**

**Date of Interdisciplinary Team Meeting(s):**

**Interdisciplinary Team Participants**:

**Date Summary Sent to Team Participants:**

| Quality Outcome | HCBS/CMS Assurances | Concerns / Observations/Positive Areas | Action Step Narrative (Positive Areas: NA) | Responsible Person | Projected Completion Date | APTS | APTS Resolution Date |
|---|---|---|---|---|---|---|---|
| **Healthy Living** | Service planning process is conducted to ensure the health and welfare of individuals. | | | | | | |
| **Safety & Security** | The setting ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint. | | | | | | |

## Enhancements for Consideration: ____

## Instructions for the Support Coordinator:

1. This form is used as written notification about the outcome of the Quality of Services Focus Review and the interdisciplinary team meeting.
2. When each of the agreed upon Action Steps is completed, please notify_____,_____ Regional Office QE.

CC: Targeted Case Management Entity Representative
Service Provider Representative, if applicable
Technical Assistance Coordinator, if applicable
Provider Relations, if applicable
QE Lead